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Welcome to IVFMD Texas!

We are pleased to welcome you to our practice and take part in your fertility journey. At IVFMD, our goal is to provide you with the highest quality of professional care while ensuring individualized attention throughout every interaction. We are here to ensure you have the best experience possible.

Prior to your first appointment, **please review and complete the enclosed New Patient Form packet.** Inside, you will find our Patient Registration Intake Form, HIPAA Policies, Personal Health Questionnaire, Pharmacy Information, Office Consent Forms, and Medical Record Release Forms.

Reviewing and completing these forms prior to your appointment will make the initial check-in process much easier and smoother.

We look forward to seeing you soon.

Thank you again for choosing IVFMD, where hope is born.

IVFMD Texas

Prepare for your first appointment at IVFMD.
Scan the QR code to learn what to expect at your first appointment.

Irving | 7501 Las Colinas Blvd., Suite 200A Irving, TX 75063 | Phone: 972-506-9986 | Fax: 972-506-0044
Arlington | 600 W Mayfield Rd., Arlington, TX 76014 | Phone: 817-701-1290 | Fax: 817-701-1297
Dallas | 8140 Walnut Hill Lane, Suite 805, Dallas, TX 75231 | Phone: 972-506-9986 | Fax: 972-506-0044

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General Patient Information

Patient Name: _____ _____ _____
First (Nombre) Middle (Inicial) Last (Apellido)

Home Address: _____
Street (Direccion)

City _____ State _____ Zip/Postal Code _____
(Ciudad) (Estado) (Postal)

Telephone Home # _____ Work # _____ Cell # _____
(Casa #) (Trabajo #) (Cellular #)

Birthdate _____ Age _____ SSN # _____
(Fecha de Nacimiento) (Edad) (Seguro Social)

Marital Status ☐ Married ☐ Single ☐ Common Law Occupation _____
(Marital) (Ocupacion)

Employer _____ Employer's Address _____
(Empleador) (Direccion)

Insurance Name _____ Insurance ID # _____ Group # _____
(Aseguranza) (Numero de Poliza)

Responsible Party ☐ Self ☐ Spouse ☐ Other _____

Responsible Party's Name _____ Occupation _____

Responsible Party's Employer _____

Responsible Party Employer Address _____

Who referred you ? _____ Primary Care Physician _____
(Quien le recomendo esta oficiana?)

Emergency Contact Person _____ Phone # _____

INSURANCE AUTHORIZATION: I hereby authorize **IVFMD & Advanced Reproductive Laboratory (ARL)** to furnish information to my insurance carriers concerning my illness and treatment. I agree that if I fail to notify IVFMD & ARL of insurance change or obtain required referrals or preauthorization for services, I will be responsible for those charges.
AUTORIZACION DE SEGURO: Autorizo **IVFMD & Advanced Reproductive Laboratory** que provea informacion medica de mi persona a las companias de seguro necesaria s. Convengo que si no notifico ARCC & ARL del cambio del seguro u obtener requirió remisiones o el preauthorization para los servicios, yo seré responsable de esas cargas.

ASSIGNMENT OF BENEFITS: I hereby assign **IVFMD & Advanced Reproductive Laboratory** all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.
AUTORIZACION DE BENEFICIOS: Asigno **IVFMD & Advanced Reproductive Laboratory** los beneficios del seguro, por servicios prestados a mi persona o dependientes mios. Entiendo que soy responsable por aquellos gastos no cubiertos por las companias de seguros.

_____ _____
Signature of Authorized Person (Firma de la Persona Autorizada) Date (Fecha)

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Partner Information

Partner's Name: _____ _____ _____
First (Nombre) Middle (Inicial) Last (Apellido)

Home Address: _____
Street (Direccion)

City _____ State _____ Zip/Postal Code _____
(Ciudad) (Estado) (Postal)

Telephone Home # _____ Work # _____ Cell # _____
(Casa #) (Trabajo #) (Cellular #)

Birthdate _____ Age _____ SSN # _____
(Fecha de Nacimiento) (Edad) (Seguro Social)

Marital Status ☐ Married ☐ Single ☐ Common Law Occupation _____
(Marital) (Ocupacion)

Employer _____ Employer's Address _____
(Empleador) (Direccion)

Insurance Name _____ Insurance ID # _____ Group # _____
(Aseguranza) (Numero de Poliza)

Responsible Party ☐ Self ☐ Spouse ☐ Other _____

Responsible Party's Name _____ Occupation _____

Responsible Party's Employer _____

Responsible Party Employer Address _____

Who referred you ? _____ Primary Care Physician _____
(Quien le recomendo esta oficiana?)

Emergency Contact Person _____ Phone # _____

INSURANCE AUTHORIZATION: I hereby authorize **IVFMD & Advanced Reproductive Laboratory (ARL)** to furnish information to my insurance carriers concerning my illness and treatment. I agree that if I fail to notify IVFMD & ARL of insurance change or obtain required referrals or preauthorization for services, I will be responsible for those charges.
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New Patient Medical Questionnaire

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Patient Name: _____ Age: _____ Occupation: _____

Marital Status: ☐ Legally Married ☐ Common Law ☐ Single ☐ Same Gender

Partner's Name: _____ Age: _____ Occupation: _____

Your ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Ashkenazi ☐ Other: _____

Partner's ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Ashkenazi ☐ Other: _____

Name of your OBGYN: _____ Who referred you? ☐ Self ☐ Friend ☐ PCP ☐ OBGYN

A. Medical History for Patient Assigned Female at Birth:

1. Medication(s) you are on: _____
2. Allergies: ☐ None known ☐ Iodine ☐ Shellfish ☐ Peanuts
   Drug allergies (list symptoms): _____
3. Do you use: ☐ Tobacco ☐ Alcohol ☐ Drugs How much: _____
4. Date of last Pap: _____ ☐ Not yet ☐ Normal ☐ Abnormal
5. Date of mammogram: _____ ☐ Not yet ☐ Normal ☐ Abnormal
6. Please indicate any significant illness you have had:

☐ Anorexia or Bulimia	☐ Asthma	☐ Rheumatoid arthritis	☐ Crohn's or Ulcerative colitis
☐ Diabetes	☐ Heart disease	☐ Hepatitis ☐ B or ☐ C	☐ Hypertension
☐ Hypothyroidism	☐ Hyperthyroidism	☐ Kidney disease	☐ Lupus
☐ Mitral valve prolapse	☐ Rheumatic fever	☐ Seizure	☐ Stroke
☐ Venous thrombosis	☐ Ulcer (GI)	☐ Other _____	

B. Surgical History

1. ☐ Abortion ☐ D&C ☐ Cryosurgery ☐ LEEP/conization Year(s): _____
2. _____
3. _____
4. _____
5. _____

C. Menstrual History

1. How often do you have your periods? _____
2. Do you have to shave or wax facial hair every week? _____ Yes ☐ No ☐
3. Do you have breast discharge? ☐ Left ☐ Right Color: _____ Yes ☐ No ☐
4. Do you have hot flashes? How often? _____ Yes ☐ No ☐
5. Do you: ☐ Spot 2-3 days before your period? ☐ Pass quarter size clots? Yes ☐ No ☐
6. When was your thyroid hormone last checked? _____
7. Do you have painful cramps with your periods? Yes ☐ No ☐

D. Sexual History

1. Do you have pain with intercourse? Yes ☐ No ☐
2. How often do you have intercourse? _____
3. Have you had 3 or more sexual partners in the past? Yes ☐ No ☐
4. Have you ever had an abnormal Pap smear? When? _____ Yes ☐ No ☐
5. Have you had: ☐ PID ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV ☐ Trichomonas Yes ☐ No ☐
6. Have you ever used: ☐ Birth control pill ☐ IUD ☐ Depo-Provera Yes ☐ No ☐

E. Review of System

1. Over the past 2 years have you ☐ gained or ☐ lost weight? _____lbs Yes ☐ No ☐
2. Do you exercise? How often? _____ Type? _____ Yes ☐ No ☐
3. Has your mother reached menopause? At what age? _____ Yes ☐ No ☐

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F. Pregnancy History

☐ Not Applicable

Year	Is current partner the father?	Miscarriage?	Terminated?	Vaginal birth or C-section?	Baby's sex	Complication

G. Fertility Treatment History

☐ Not Applicable

Treatment	Year	# Cycle	# IUI	Physician	Outcome
Clomid					
Letrozole/Femara					
Injectable meds (Bravelle, Follistim, Gonal-f, Menopur)					
Clomid + Injectable					
Letrozole/Femara + Injectable					
In Vitro Fertilization					
Frozen Embryo Transfer					

H. Family Medical History

Please indicate maternal (M) or paternal (P) side for each condition.

- ☐ Cystic fibrosis _____
- ☐ Hemophilia _____
- ☐ Musc dystrophy _____
- ☐ Sickle cell _____
- ☐ Tay sach _____
- ☐ Thalassemia _____
- ☐ Mental disease _____
- ☐ Other _____

- ☐ Cancer (please specify type(s) below):
  Breast _____ Uterine _____
  Ovarian _____ Colon _____
  Other: _____
- ☐ Diabetes: _____
- ☐ Hypertension _____
- ☐ Heart attack _____ ☐ Stroke _____
- ☐ Hypothyroid _____ ☐ Hyperthyroid _____

I. Medical History for Patient Assigned Male at Birth: ☐ N/A (do not have male partner)

		YES	NO
1.	Have you been credited with any pregnancy (including miscarriage)? # of pregnancies: _____ # of children: _____ Age of youngest child: _____	☐	☐
2.	Have these pregnancies/children been with your current partner?	☐	☐
3.	Have you ever had: ☐ Mumps ☐ Radiation Therapy ☐ Chemotherapy	☐	☐
4.	Do you have: ☐ Diabetes ☐ Hypertension ☐ Erectile Problem	☐	☐
5.	Do you take testosterone? _____	☐	☐
6.	Do you take any regular medication? _____	☐	☐
7.	Did you ever have infection of the prostate? _____	☐	☐
8.	Have you ever had injury to groin or genitalia? _____	☐	☐
9.	Do you have: ☐ Varicocele Surgery ☐ Testicular Surgery ☐ Vasectomy Reversal	☐	☐
10.	Do you smoke? How much? _____	☐	☐
11.	Do you drink alcohol? How much? _____	☐	☐
12.	Do you use recreational drugs? What type? _____	☐	☐

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Preferred Pharmacy

Please fill out the following information:

Patient Name: _____

DOB: _____

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone #: _____

The pharmacy you provide will be used to send all of your prescriptions.

Thank you,

IVFMD

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Patient Name:_____ PID#:_____

Advance Beneficiary Notice of Non-Covered Services (ABN)

You have requested we bill your insurance for some/ all fertility services. Your insurance may not offer coverage for some/all services, even though your health care provider advises these services are medically necessary and justified.

If your insurance doesn't pay for rendered services, you may have to pay.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services recommended by my physician.
- Note: If you choose Option 1 or 2, we may help you to appeal to your insurance company for coverage.

OPTIONS:

Check only one box.

☐ **OPTION 1.** I want the services listed below. I may be asked to remit payment now, but I also want my insurance billed for an official decision on payment, which is sent to me as an Explanation of Benefits. I understand that if my insurance does not pay, I am responsible for payment, but I can appeal to the insurance carrier. If the insurance carrier does pay, you will refund any payments I made to you, less co-pays or deductibles, upon discharge from the clinic. Please note it will take about 60 days from the discharge date to receive the refund.

☐ **OPTION 2**. I want the services listed below, but do not bill my insurance company. I will be asked to remit payment now as I am responsible for payment.

☐ **OPTION 3.** I do not want the services listed below. I understand with this choice I am not responsible for payment.

Recommended Services:

This notice gives our opinion, not a denial from your insurance company. If you have other questions on this notice, please reach out to the billing team, or the physician before you sign below.

Signing below means that you have received and understand this notice. You may also receive a copy.

Signature: _____ Date: _____

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Couples Policy

At IVFMD we are dedicated to helping couples and individuals build their families. We are committed to providing all individuals with a complete, yet cost efficient infertility evaluation. We welcome patients of all backgrounds and beliefs, and respect the personal choices that individuals and couples make in their lives. However, because we have an integral role in bringing new life into this world, we would like to clearly define how we approach patients and their partners regarding the services that we offer to them.

Married woman: Legally married - Marriage certificate, share last name. Patient may use her husband's semen for IUIs or IVF. If needed, donor sperm is an option as well.

Single woman: Not legally married. Patient may use cryopreserved donor sperm from a bank.

Common Law: Couples not legally married but who live together, consider themselves as married and introduce themselves to society as such - Demonstrate official proof of cohabitation for 1 year or more (tax forms, home ownership, joint lease or utility bills) or that you already have a child together. Patients will be treated as couples with a marriage certificate.

Other: You do not consider yourself single and do not meet criteria for being married or in a common law relationship. We will gladly provide you with an evaluation. To receive treatment by us, we would like to have a clear definition for the source of the sperm. If you cannot clearly define the relationship with your partner, we will not be able to do ovulation induction or use his sperm in the process. If you find yourself in this situation, you may consider defining your relationship (getting married) or ordering donor sperm (which is clearly defined by the sperm bank as donor sperm). Otherwise we will gladly refer you to other Reproductive Endocrinologists in the community.

Thank you for understanding our Couples Policy. Please let us know if you have any questions or concerns.

I understand and agree to this Couples Policy,

Patient Name (print): _____

Patient Signature: _____ Date: _____

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Advance Patient Notice for Use of a Non-Participating Provider or Facility

As a patient you have the right to receive services at a participating facility or by a participating physician or provider in order to obtain full benefits under your health plan. However, if you are receiving this notice you have chosen to have your service or procedure done at a non-participating facility. We would advise that if you have questions or would like to locate an in network physician, provider or facility to provide the services or procedures, please contact your carrier at the telephone number listed on the back of your card.

By placing my signature below, I have acknowledged the following:

1) I am aware that I am using a non-participating facility for my IVF (In-Vitro Fertilization) procedures.

2) I was given the opportunity to contact my carrier before obtaining these services to confirm my benefits for non-network services and to obtain names of participating facilities.

3) I am voluntarily choosing on behalf of myself to receive service or procedure from a non-participating facility. Furthermore, I understand and agree that I am a self-paying patient for my IVF (In Vitro Fertilization) procedure and IVFMD/Advanced Reproductive Lab will not submit my claims to my carrier on my behalf. Upon the completion of my IVF treatment I will be responsible for submitting my claims to my carrier and accept all implications as set forth by my carrier.

Patient Name (print): _____

Patient Signature: _____ Date: _____

IVFMD Staff Signature: _____

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Financial Policy

Thank you for choosing **IVFMD** as your health care provider. We are committed to the success of your treatment. The following form is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Insurance

We may accept assignment of insurance benefits upon your first visit. However, we do require that you pay your portion of the bill at the time of service (ie. co-pay, deductible, etc.). We will do everything reasonably required to facilitate the filing of your insurance claim. You need to provide us with correct insurance information along with all other relevant documents (i.e. secondary insurance, change in insurance plan).

Your insurance is a contract between you and your insurance company. Please be aware that your insurance carrier may deny coverage for services that are in our opinion usual, customary, and medically necessary. Your carrier may declare the treatment as not medically necessary and thus not covered. We charge what is usual and customary for our area. Because the bill is your responsibility, should your insurance not pay, you will be billed for the remaining balance.

Under special circumstances, we offer an extended payment plan with prior approval. If your account becomes 90 days delinquent from the last day of service, please understand that your account will be forwarded to a collection agency.

Missed Appointments

Unless canceled at least **2 business days** in advance, our policy is to charge $30 for any missed appointments, such as, cancellations, rescheduled-appointments, or no-show appointments (subject to extenuating circumstances). Please help us serve you better by keeping scheduled appointments.

Returned Checks

There will be a $25 service charge for returned checks.
Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I understand and agree to this Financial Policy,

Patient Name (print): _____

Patient Signature: _____ Date: _____

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Credit & Refund Policy

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Effective April 2025

We understand that plans can change, and we want to be transparent about what happens if a treatment cycle is canceled or not completed. Please review the following policy carefully.

Refunds are not provided. Instead, a credit will be applied toward future services based on the timing and stage of your treatment. All credits are handled on a case-by-case basis in accordance with the information below.

If your cycle is canceled immediately after payment:
- A clinical management fee will be applied, and the remaining balance will be issued as a credit toward future services.

If your cycle is canceled after stimulation has begun but before egg retrieval:
- $3,700 will be retained to cover monitoring and clinical management.
- $7,400 will be credited toward future cycle(s).

If your cycle is canceled after egg retrieval but before any lab work is done:
- $7,400 will be retained.
- $3,700 will be credited toward future cycle(s).

If oocytes are retrieved and laboratory services begin:
- No credit will be issued.

If additional services were paid for but not performed:
- Biopsy for PGT: $2,600 refundable
- Unlimited transfers: $2,000 refundable
- Any other additional services paid and not rendered are fully refundable if no issues, recoupments or chargebacks.

Patient Acknowledgment

By signing below, I confirm that I have read and understand the **Credit & Refund Policy** outlined above. I acknowledge that no refunds will be issued, and that any credits toward future services will be applied in accordance with this policy. I understand that I may contact a financial counselor at the clinic if I have any questions or need further clarification.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

Need Assistance?

- **For questions before your treatment begins**, contact our financial consulting team at: financialconsult@ivfmd.net or call your IVFMD clinic directly.
- **For billing questions after services have been provided**, contact our billing department at: billing@ivfmd.net or by calling 469-902-7343.

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After Hours Policy

Our staff is available to answer calls of an urgent nature before and after office hours. However, we ask that you exercise thoughtfulness in your decision to call, especially if the call concerns instruction for injection of medications. Please do not call to ask about mixing or administration of medications between 5 PM to 8 AM.

Please note that a **$20.00 fee** will be assessed for calls of the following nature made before or after office hours:

- Calling to schedule an appointment.
- Paging the physicians during office hours (instead of calling the office number).
- Calling to refill medications.
- Calling to inquire about insurance issues such as authorization for appointment or medications.
- Calling for test results unless the nurse has left you a message to do so.

The Arlington and Irving offices are open for calls on:

Monday and Wednesday	8:00 am to 6:00 pm
Tuesday and Thursday	8:00 am to 5:00 pm
Friday	8:00 am to 2:00 pm
Saturday	8:00 am until 12:00 pm (noon)

Monday through Thursday a lunch break is taken from 1:00 pm until 2:00 pm

We appreciate your understanding and cooperation.

Patient Signature: _____ Date: _____

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2) I was given the opportunity to contact my carrier before obtaining these services to confirm my benefits for non-network services and to obtain names of participating facilities.

3) I am voluntarily choosing on behalf of myself to receive service or procedure from a non-participating facility. Furthermore, I understand and agree that I am a self-paying patient for my IVF (In Vitro Fertilization) procedure and IVFMD/Advanced Reproductive Lab will not submit my claims to my carrier on my behalf. Upon the completion of my IVF treatment I will be responsible for submitting my claims to my carrier and accept all implications as set forth by my carrier.

Patient Name (print): _____

Patient Signature: _____ Date: _____

IVFMD Staff Signature: _____

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Notification of Privacy Policies

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Introduction

At IVFMD, we are committed to treating you and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we disclose that information. It also describes your rights as they relate to your protected health information. This notice applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit IVFMD, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed are actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this
- state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the
- outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record information is the physical property of IVFMD, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided fro in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided for in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR
- 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

IVFMD is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to
- information we collect and maintain for you,
- Abide by terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

For More Information or to Report a Problem

You may contact our Privacy Officer, Kristie Martinets, at 972-506-9986.

If you believe your privacy has been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint. The address for the OCR is:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment, and Health Operation

We will use your health information for treatment

For example: Information obtained by a nurse, physician, or other members of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team, who will then record the actions they took and their observations. In that way, the physician will know how you respond to the treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from this practice.

We will use your health information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department, anesthesiology, radiology, and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders by mail, answering machine messages, or your voicemail, or to provide information about treatment alternatives or other health- related benefits and services that may be of interest to you.

Public Health: We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability as required by law.

Worker compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation.
Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

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Acknowledgement of Receipt of Privacy Notice - Primary Patient

I have been presented with a copy of **Notice of Privacy Policies** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following person(s) to obtain information about my care including laboratory results:

☐ Partner Name: _____

☐ Other Name(s): _____

☐ None

I have the right to change these restrictions and have the most recent authorization used.

Patient's Signature: _____ **Date:** _____

Clinical Reviewer (employee): _____

Privacy officer/designee signature: _____

Restriction accepted: ☐ **Yes** ☐ **No**

Patient notified of acceptance/denial: ☐ **Yes** ☐ **No**

Employee Name: _____ Date: _____

Irving | 7501 Las Colinas Blvd., Suite 200A Irving, TX 75063 | Phone: 972-506-9986 | Fax: 972-506-0044
Arlington | 600 W Mayfield Rd., Arlington, TX 76014 | Phone: 817-701-1290 | Fax: 817-701-1297
Dallas | 8140 Walnut Hill Lane, Suite 805, Dallas, TX 75231 | Phone: 972-506-9986 | Fax: 972-506-0044

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Acknowledgement of Receipt of Privacy Notice - Patient's Partner

I have been presented with a copy of **Notice of Privacy Policies** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following person(s) to obtain information about my care including laboratory results:

☐ Patient Name: _____

☐ Other Name(s): _____

☐ None

I have the right to change these restrictions and have the most recent authorization used.

Partner's Signature: _____ **Date:** _____

Clinical Reviewer (employee): _____

Privacy officer/designee signature: _____

Restriction accepted: ☐ **Yes** ☐ **No**

Patient notified of acceptance/denial: ☐ **Yes** ☐ **No**

Employee Name: _____ Date: _____

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Authorization for Disclosure of Confidential Information

Patient's Name: _____ Chart #: _____

Address : _____

Date of Birth: _____

I hereby authorize and request:

Doctor's Name: _____

Address : _____

Phone: _____ Fax: _____

To release the following information to:

☐ **7501 Las Colinas Blvd, Ste 200A**
Irving, TX 75063
Fax: 972-506-0044

☐ **600 West Mayfield Rd**
Arlington, TX 76014
Fax: 817-701-1297

☐ **8140 Walnut Hill Lane, Ste 805**
Dallas, TX 75231
Fax: 972-506-0044

Check all that may be released:

☐ Infertility notes and relevant studies only

☐ Other (please specify): _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing any time prior to the expiration date.

Patient's Signature: _____ Date: _____

Clinical Reviewer: _____

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Medical Record Release Authorization

Patient's Name: _____ DOB: _____

Address : _____

City: _____ State: _____ Zip: _____

Before signing authorization for the release of my medical record, I acknowledge the following:

1. I understand that there will be a charge for labor and material cost in photocopying my medical record ($25 for the first 20 pages and $0.50 for each additional page). I will be notified of the total amount and will pay this fee before my record is released.

2. I understand that my medical record will be mailed within one week after payment is received.

I have read and agreed with the above conditions and authorize:

IVFMD

to release the following information to:

Name: _____

Address : _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Check all that may be released:

☐ Entire record

☐ Infertility notes and relevant studies only

☐ Other (please specify): _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing any time prior to the expiration date.

Patient's Signature: _____ Date: _____

Irving | 7501 Las Colinas Blvd., Suite 200A Irving, TX 75063 | Phone: 972-506-9986 | Fax: 972-506-0044
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New Patient Information

Primary Patient Information

Name: _____ _____ _____ Date of Birth: _____/_____/_____
First Middle Last Month Day Year

Home Address: _____ _____ _____ _____
Street City State Zip/Postal Code

Marital Status: ☐ Single ☐ Married ☐ Common Law ☐ Prefer Not to Share SSN #:_____-_____-_____

Primary Phone: _____ ☐ Work ☐ Cell Alternate Phone:_____ ☐ Work ☐ Cell

Email:_____ Preferred Method of Contact: ☐ Phone ☐ Email

Ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Ashkenazi ☐ Other: _____ ☐ Prefer not to share

What sex was originally listed on your birth certificate? ☐ Male ☐ Female ☐ Decline to answer

What are your preferred pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Other:_____

Do you think of yourself as: ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning
☐ Don't know ☐ Decline to answer ☐ Other (Please specify):_____

Do you think of yourself as: ☐ Male ☐ Female ☐ Transgender man ☐ Transgender woman ☐ Neither exclusively male nor female
☐ Don't know ☐ Decline to answer ☐ Other (Please specify):_____

How did you hear about IVFMD? ☐ Physician Referral ☐ Friend/Family ☐ Web Search ☐ Social Media ☐ Other:_____

Who referred you? ☐ Self ☐ Friend ☐ PCP ☐ OBGYN ☐ Other: _____ Name of Referring Person: _____

Partner's Information (if applicable)

Name: _____ _____ _____ Date of Birth: _____/_____/_____
First Middle Last Month Day Year

Primary Phone: _____ ☐ Work ☐ Cell Alternate Phone:_____ ☐ Work ☐ Cell

Email:_____ Preferred Method of Contact: ☐ Phone ☐ Email

Ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Ashkenazi ☐ Other: _____ ☐ Prefer not to share

What sex was originally listed on your birth certificate? ☐ Male ☐ Female ☐ Decline to answer

What are your preferred pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Other:_____

Do you think of yourself as: ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning
☐ Don't know ☐ Decline to answer ☐ Other (Please specify):_____

Do you think of yourself as: ☐ Male ☐ Female ☐ Transgender man ☐ Transgender woman ☐ Neither exclusively male nor female
☐ Don't know ☐ Decline to answer ☐ Other (Please specify):_____

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Patient Medical History & Information

Patient Name: _____ Sex Assigned at Birth: ☐ M ☐ F

Partner Name (if applicable): _____ Sex Assigned at Birth: ☐ M ☐ F

Have you/your partner visited a fertility specialist before? ☐ Yes ☐ No Date of last visit: _____

Medical History for Patients Assigned Female at Birth:

1. Medication(s) you are on: _____
2. Allergies: ☐ None known ☐ Iodine ☐ Shellfish ☐ Peanuts
   Drug allergies (list symptoms): _____
3. Do you use: ☐ Tobacco ☐ Alcohol ☐ Drugs How much: _____
4. Date of last Pap: _____ ☐ Not yet ☐ Normal ☐ Abnormal
5. Date of mammogram:_____ ☐ Not yet ☐ Normal ☐ Abnormal
6. Please indicate any significant illness you have had:

☐ Anorexia or Bulimia	☐ Asthma	☐ Rheumatoid arthritis	☐ Crohn's or Ulcerative colitis
☐ Diabetes	☐ Heart disease	☐ Hepatitis ☐ B or ☐ C	☐ Hypertension
☐ Hypothyroidism	☐ Hyperthyroidism	☐ Kidney disease	☐ Lupus
☐ Mitral valve prolapse	☐ Rheumatic fever	☐ Seizure	☐ Stroke
☐ Venous thrombosis	☐ Ulcer (GI)	☐ Other _____	

Surgical History

1. ☐ Abortion ☐ D&C ☐ Cryosurgery ☐ LEEP/conization Year(s):_____
2. _____
3. _____
4. _____
5. _____

Menstrual History

1. How often do you have your periods?_____
2. Do you have to shave or wax facial hair every week? _____ Yes ☐ No ☐
3. Do you have breast discharge? ☐ Left ☐ Right Color: _____ Yes ☐ No ☐
4. Do you have hot flashes? How often?_____ Yes ☐ No ☐
5. Do you: ☐ Spot 2-3 days before your period? ☐ Pass quarter size clots? Yes ☐ No ☐
6. When was your thyroid hormone last checked? _____
7. Do you have painful cramps with your periods? Yes ☐ No ☐

Sexual History

1. Do you have pain with intercourse? Yes ☐ No ☐
2. How often do you have intercourse?_____
3. Have you had 3 or more sexual partners in the past? Yes ☐ No ☐
4. Have you ever had an abnormal Pap smear? When? _____ Yes ☐ No ☐
5. Have you had: ☐ PID ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV ☐ Trichomonas Yes ☐ No ☐
6. Have you ever used: ☐ Birth control pill ☐ IUD ☐ Depo-Provera Yes ☐ No ☐

Review of System

1. Over the past 2 years have you ☐ gained or ☐ lost weight? _____lbs Yes ☐ No ☐
2. Do you exercise? How often? _____ Type? _____ Yes ☐ No ☐
3. Has your mother reached menopause? At what age? _____ Yes ☐ No ☐

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